EDMUND G. BROWN JR., Attorney General
of the State of California
WILBERT E. BENNETT
Supervising Deputy Attorney General
KIM M. SETTLES, State Bar No. 116945
Deputy Attorney General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 622-2138
Facsimile: (510) 622-2270

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2008-227
NIMFA REALEZA PUNZALAN, a.k.a. **NIMFA REYES REALEZA PUNZALAN** **2341 Ascot Parkway** **Vallejo, California 94591** **Registered Nurse License No. 422347** Respondent.	**ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1988, the Board of Registered Nursing issued Registered Nurse License Number 422347 to NIMFA REALEZA PUNZALAN, also known as NIMFA REYES REALEZA PUNZALAN (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2008, unless renewed.

//

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Title 16, California Code of Regulations, section 1443 defines incompetence as "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

7. Title 16, California Code of Regulations, section 1443.5 defines standards of competent performance as follows:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

. . .

//

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed."

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

9. On or about June 27 through July 1, 2005, while employed as a charge (registered) nurse at the San Francisco County Jail, in San Francisco, California, respondent provided care to patient/inmate E.M.[1] Respondent provided said nursing care in an incompetent and/or grossly negligent manner by failing to formulate a nursing diagnosis, failing to evaluate or access the patient's physical condition, and failing to act as an advocate for the patient. The circumstances are as follows:

(a) E.M. presented to San Francisco County Jail, on June 21, 2005, as a patient/inmate with a medical history of high blood pressure and congestive heart failure. On June 27, 2005, E.M. was moved from his jail cell to the clinic, after he complained of flank pain. Later that same day, E.M. was returned to his cell, and respondent responded to a "man down" code and charted that she found E.M. lying face down with a small amount of emesis. According to cell mates, E.M. was walking and fell to the floor, complaining of "kidney pain". E.M. advised respondent that he had a heart problem and needed to be seen by his own doctor or go to San Francisco General Hospital. At that point, E.M. was temporarily placed in the clinic after respondent noted E.M.'s blood pressure as

---

1. Patient initials are used to protect the patient's privacy. Full names will be released to respondent in discovery.

199/112. Respondent charted that E.M. was "carrying on and on" about his medical problems and was "not even on the HI risk board". On June 28, 2005, Liberty Forteza, RN, responded to a "man down" code and found E.M. lying on his right side, clutching his chest. Forteza charted that E.M. complained of chest and kidney pain, headache, burning sensation, and high blood pressure. E.M. demanded to go to the hospital and was taken to the clinic for observation. On June 30, 2005, E.M. was placed in the clinic with complaints of leg pain.

(b) On or about June 30, 2005, at approximately 11:45 p.m., respondent responded to a "man down" code along with Evangeline Anacleto, RN, and Mike Fowler, LVN. E.M. was found lying face down on a mattress on the floor of his cell. E.M. stated that he was "stressed out" and denied chest pain or shortness of breath. The nurses left E.M. in his cell and returned to the clinic to access and review E.M.'s medical records. Approximately twenty minutes later, a sheriff's deputy notified respondent and Anacleto that E.M. had been placed in a "safety cell", where inmates are checked by deputies every fifteen minutes. Respondent did not question the deputy's decision to place E.M. in a "safety cell", and failed to advocate to place E.M. in the clinic, as an alternative. At that time, respondent and Anacleto went to the "safety cell" and visually inspected E.M. for injuries, and returned to the clinic. Thereafter, respondent received a telephone call from a deputy at approximately 3:40 a.m., that same day, asking someone to check E.M.'s safety cell. Respondent informed the deputy that Anacleto was on her way. Respondent received a "man down" call over the radio at approximately 4:00 a.m., and sent Fowler to respond because she was caring for three or four patients in the clinic. Respondent went to E.M.'s cell approximately ten minutes later, however E.M. was pronounced dead at 4:08 a.m. The cause of death was listed as "acute cocaine intoxication", with acute pyelonephritis, bronchopneumonia, and hypertensive cardiovascular disease listed as other significant conditions contributing to death.

(c) Respondent, in rendering nursing care to E.M. as a charge nurse during the above-referenced time period, failed to formulate a nursing diagnosis based on the information gathered from the patient and failed to evaluate or assess E.M.'s physical condition, notwithstanding an extremely elevated blood pressure of 119/112 on June 27, 2005.

10. Respondent's conduct, in failing to formulate a nursing diagnosis based on information gathered from the patient, as set forth in paragraph 9, above, constitutes incompetence and/or gross negligence and provides grounds for disciplinary action under Code section 2761(a)(1).

11. Respondent's conduct, in failing to evaluate or assess E.M.'s physical condition, as set forth in paragraph 9, above, constitutes incompetence and/or gross negligence and provides grounds for disciplinary action under Code section 2761(a)(1).

12. Respondent's conduct, in failing to advocate for E.M. to be placed in the clinic, when the deputy advised her that E.M. would be placed in a "safety cell" where he would be monitored by unlicensed personnel, as set forth in paragraph 9, above, constitutes incompetence and/or gross negligence and provides grounds for disciplinary action under Code section 2761(a)(1).

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent's conduct, by making judgmental comments in E.M.'s medical record, to wit: that "he's carrying on and on . . . . he is not even on the HI risk board", without attempting to determine the actual cause and/or reason for his behavior or take action to address his concerns, as set forth in paragraph 9, above, constitutes general unprofessional conduct and provides grounds for disciplinary action under Code section 2761 (a).

//

//

//

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 422347, issued to NIMFA REALEZA PUNZALAN, a.k.a. NIMFA REYES REALEZA PUNZALAN NIMFA PUNZALAN.

2. Ordering NIMFA REALEZA PUNZALAN to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/23/08

Elliot Hawley for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2007402676
90071606.wpd